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# **'THE FORGOTTEN WOMEN': A CASE STUDY OF REPRODUCTIVE HEALTH ISSUES AMONG WOMEN LIVING WITH DISABILITIES AND EDUCATIONAL IMPLICATIONS IN HARARE, ZIMBABWE**

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## **Abstract**

*The female population in Zimbabwe is currently pegged at 5 997 477 (Central Statistical Office, 2002). Women living with disabilities (WLWD) represent 10% (599 747) of the total female population yet their reproductive health needs are poorly understood and not catered for. The study primarily identifies the reproductive health issues for WLWD by specifically investigating knowledge, attitudes, beliefs and practices pertaining to their reproductive health. It also establishes contributing factors to WLWD's reproductive health practices and identifies the barriers encountered by such women in their bid to seek reproductive health. The paper is based on survey data and focus group discussions from WLWD; and information from key informants. The study revealed that WLWD do not effectively utilize the available reproductive health services such as contraceptives, access to health information and treatment of STIs. Consequently, they face challenges that include lack of contraceptive use, and increased vulnerability to sexually transmitted diseases including HIV and AIDS. The study also noted that the aforementioned WLWD's problems are a result of background variables which include socio-economic and traditional factors. The attitude of the society and healthcare providers undermine WLWD's access to reproductive health services. Proximate determinants such as lack of reproductive health knowledge, inaccessibility, unacceptability and unaffordability of reproductive health services underlie the WLWD's reproductive health issues. Thus, WLWD have therefore been referred to as 'the forgotten women'. The study has thus recommended the government and other relevant stakeholders to formulate policies that promote equal access to RH services for the WLWD as other fellow women.*

## **Background to the Study**

The World Health Organization (WHO, 2007) estimated the world population to be 6.7 billion. Out of the aforementioned world population, WHO (2007) further stated that the extent of disablement varied from 10 to 20%. Three quarters of people living with disabilities (about 450 million), as stated by UNFPA (2005), are said to be living in the developing countries. As for Zimbabwe, the Central Statistical Office (CSO, 2004) stipulates that 10% (599 747), of the total female population (set at 5 997 477) is made up of WLWD.

Historical analysis of reproductive health service delivery in African countries, Zimbabwe included, has shown that WLWD have been subjugated and disadvantaged. Such women are on the receiving end of the dose of a double tragedy. The first tragedy is that they are women. As such, the feminist theory by Mackinnon (1987) asserts the distinctive value of womanhood against patriarchal denigration. According to Mackinnon (1987), the values of society are geared to men. Secondly, they are not perceived as 'normal' women since they are disabled. Such perceptions have allowed society to believe that it is permissible to objectify these women and debate their right to freedom and personal inviolability.

Bullard and Knight (2005) propounded that WLWD over the world have health concerns that are very distinct from other women. More so, Littner et al (2006) noted that these concerns have been neglected for too long and denied by societies in which they live. Thus, their needs are often not met or recognized. It is reported that in many parts of Africa, substantial proportions of the general female population have limited or no access to reproductive health services (International Leadership Forum for WLWD, 2006).

According to Smith et. al. (2003), WLWD's experiences in one place are replicated in other places elsewhere, for example, little or no educational attainment and limited exposure to mass media. More so, WLWD are also exposed to sexually transmitted diseases (STDs), HIV and AIDS and limited use of contraceptives. Zimbabwe is a signatory to the International Human Rights Framework that offers great protection for vulnerable groups with specific conventions such as the Disabled People's Act of 1998. However, despite the government being a signatory to the international consensus, it still falls short on providing reproductive health services to WLWD. This shows that there is a gap between public declarations and the actual practice and obligation and action. Women living with disabilities have therefore been referred in this paper as *The Forgotten Women* since society seem to perceive their life style as normal. Yet they need special attention in as far as educational attainment, access to media, contraceptive use, fertility preferences, and maternal health care are concerned.

### **Conceptual Framework**

It is expected that if women with disabilities have access to reproductive health services, they are more likely to practise safe sex. Unfortunately, it appears that disability negatively impacts on this. As a result, women with disabilities are practising unsafe sex. For example, blindness as a form of disability has a negative impact on accessibility, acceptability, availability as well as affordability. Since the blind women are always in need for someone to guide them in order to access reproductive health services, such services remain inaccessible. Thus, condoms may not be available and knowledge about the dangers of unsafe sex is not acquired. This also affects the physically handicapped women who also require some assistance when it comes to mobility.

It is unfortunate that such women are in most cases led by children who lack the knowledge about where or how to reach the reproductive health services. When they are being guided by elderly persons, women with disabilities may avoid reproductive health services for fear of being known to be using such services. Thus, ways of practising safe sex remain unavailable.

The issue of affordability is also a result of disability. As has been cited by Charowa (2007), women with disabilities are among the poorest in the society. This makes it difficult for them to have the ability to cover any costs from their meager earnings from begging and vending on the mean pavements of the city.

The described situation is accentuated by attitudinal, physical and knowledge based barriers. For instance, research has indicated that health service providers view women with disabilities as asexual. In this regard, they in most cases get discouraging comments when they try to seek reproductive health. To make matters worse, WLWD themselves fear bad reception and have lost their self-esteem, hence are not confident enough to approach the service providers for reproductive health services.

Cultural beliefs have also resulted in girls with disabilities not receiving reproductive health education as society fears that disability breeds disability.

The issue of unsafe sex results in WLWD being vulnerable to STDs including HIV and AIDS. Vulnerability to STDs persists as long as information and the means to protect them continue to be inaccessible, unavailable, unacceptable and unaffordable.

As long as WLWD encounter barriers in receiving RHS, the issue of limited use of contraceptives also becomes a reproductive health issue among women with disabilities. Accessing the contraception clinics and asking for them remains not easy among women in their various forms of disabilities. The issue of acceptability, affordability, accessibility and availability as well as the physical, attitudinal and knowledge based barriers still affects contraceptive use among WLWD.

It is however important to note that women in their various forms of disability also face reproductive health problems mainly as a result of their socio-economic status. For starters, educational attainment is low among women with disabilities as parents prefer to educate the able bodied children. Poverty therefore becomes inevitable, making it difficult for WLWD to access RHS, afford it, accept condom use, contraception or even have the knowledge about STDs including HIV and AIDS. This makes them vulnerable to STDs.

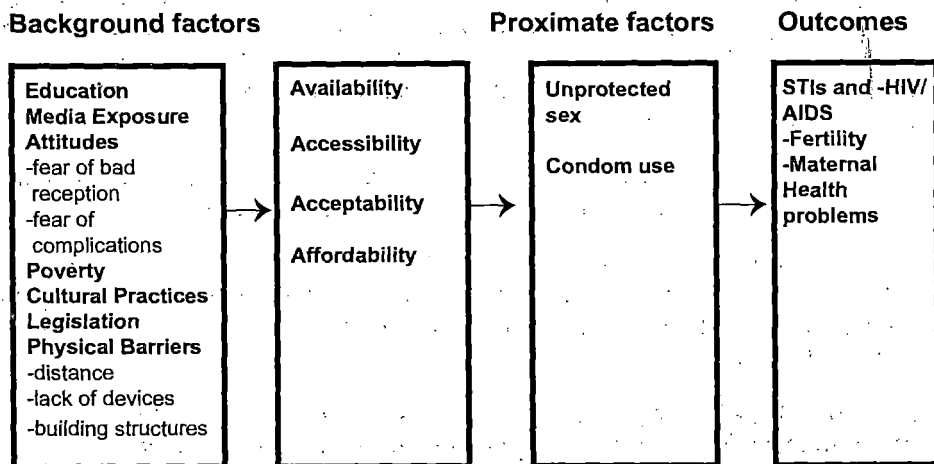
Traditional beliefs that forbid sex education to the disabled children by parents further expose them to sexual abuse since they normally become isolated and face stigmatization.

The Zimbabwean legislation continues not to adequately protect the disabled. The WLWD continue to suffer sexual abuse and fail to receive the RHS. The Disabled People's Act, although it exists, lacks the enforcement agents.

All in all, unsafe sex, sexual abuse, limited use of contraceptives and limited access to RHS, vulnerability to STDs including HIV and AIDS, are topical reproductive health issues.

### Figure 1.1: Reproductive Health issues among Women with Disabilities

Factors underlying reproductive health among women living with disabilities can be organized into background and proximate factors.



### Objectives

The main objective of the study is to establish the reproductive health concerns of the WLWD that need to be recognized in the reproductive health programmes. The study specifically sought to;

- Identify the reproductive health issues among WLWD;
- Assess the knowledge levels, attitudes and practices of WLWD with regard to reproductive health issues;
- Establish inhibiting factors to WLWD's reproductive health practices; and
- Identify the barriers encountered by WLWD in a bid to seek reproductive health.

## Methodology

The target population in this study was WLWD in the reproductive age group (aged 15 to 49). This group was targeted because it is the major segment that is expected to have access to reproductive health care and services. The study triangulated both qualitative and quantitative methods. Focus group discussions (FGDs) and in-depth interviews were used for the qualitative part of the study, while a survey was used for the quantitative aspect. Four FGDs (using an FGD guide) were carried out with WLWD. The FGDs assisted in defining the terminology used for WLWD reproductive health issues and also to formulate questions in the survey. Norms and values under girding WLWD reproductive health were clarified by FGDs. Further more, FGDs also helped to obtain normative information where participants' knowledge, attitudes, beliefs and practices (KABP) pertaining to reproductive health were drawn upon. A survey (using a questionnaire) was undertaken among WLWD within the age group 15-49 only. This was meant to quantify and determine the magnitude of WLWD reproductive health issues. To determine the number of respondents in the survey, the following formula was used:

$$N = (z^2 \cdot p \cdot q) / e^2$$
 Where:  $N$  = desired sample size;  $z^2$  = the standard normal deviate usually set at 1.96 which correspond with 95% confidence intervals;  $p$  = the proportion in the target population estimated to be WLWD;  $q$  = the estimated proportion of the target population which is not living with disabilities ( $1-p$ );  $e^2$  = desired level of precision and in this study is set at 0.05.

Therefore, the sample size was  $(1.96)^2 \cdot 0.47 \cdot 0.53 / 0.05^2 = 237$  respondents. Convenient sampling of respondents was used since the general population of WLWD was on the streets and their homes were difficult to locate. In-depth interviews (using in-depth interview guide) were undertaken from eight key informants. Such key informants included both male and female healthcare providers, National Association for Societies Caring for the Handicapped (NASCOH) and Disabled Women Support Network (DWSO) coordinators. In-depth interviews helped establish inhibiting factors to WLWD's reproductive health practices. They also helped identify the barriers encountered by WLWD in a bid to seek reproductive health. A follow up of issues raised in both focus group discussions and survey were done using in-depth interviews. SPSS and DT Search were used for quantitative and qualitative data analysis respectively. Data analysis was also based on the form of disability.

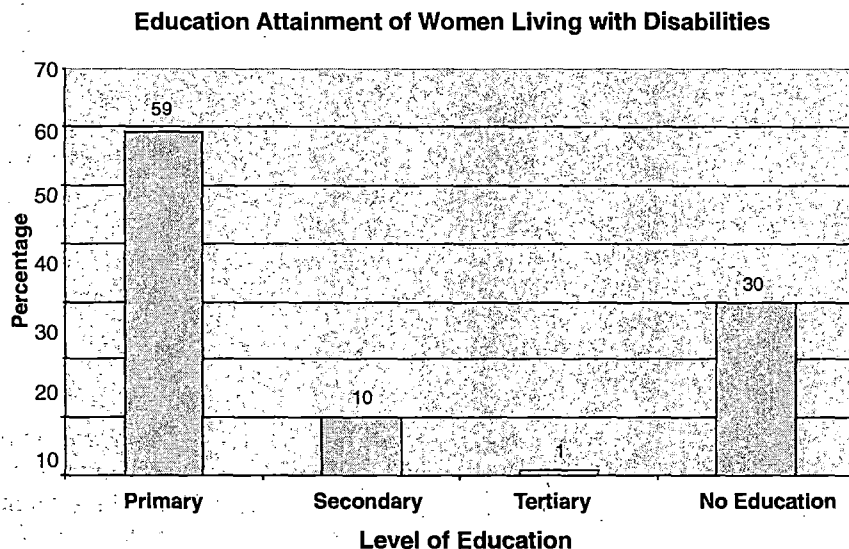
## Findings of the Study

### Educational Attainment

Results indicate that there is marked disadvantage in terms of access to education for WLWD compared to their able-bodied counterparts as most of the respondents

have a generally low educational attainment. The majority (59%) have attained primary education only (Figure 1.1).

**Figure 1.2: Percentage Distribution of Respondents by Educational Attainment**



N=237

A substantial percentage, 30%, of WLWD have never been to any formal school compared to 4% women studied in the Zimbabwe Demographic Health Survey (ZDHS) of 2005-6. One% and only 10% of WLWDs have attended tertiary and secondary school education respectively as compared to 3% and 60% respectively of the ZDHS women. Fifty-nine% of WLWDs have attended primary school compared to 33% from the ZDHS. Whilst a higher percentage of WLWDs attended primary school, the study noted the majority of these women reported not to have completed primary education.

During the FGDs, participants shared the same sentiments with one of the visually impaired respondents who echoed that;

*"I am not educated. My parents rather preferred sending my brothers to school instead of daughters. Worse still, being blind, they argued that I was never going to be of any economic value to the family."*

One key informant reported that school facilities are not compatible with the needs of children living with disabilities. In fact, the special schools in Zimbabwe are not enough and are sometimes expensive that many families can not afford.



## Media Exposure

Results of this study indicate that disabled women have limited access to the media as evidenced by the observation that most of the respondents reported that they do not have access to any form of media. The inaccessibility has been observed to differ with the type of disability as 81% of the visually impaired, 54% of the physically handicapped, 54% of the hearing impaired and 45% of other forms of disability do not have access to media as shown on Table 1.1. The table also indicates that 9% of the WLWD read newspapers once a week compared to 25% of the women in the 2005-6 ZDHS. In addition, 17% and 16%, of WLWD watch television at least once a week, listen to radio once a week respectively as compared to 48% and 36% respectively of the ZDHS women. It was also revealed that 59% of WLWD do not have access to media at all compared to only 44% of the women studied in the ZDHS.

**Table 1.1: Percentage Distribution of Respondents by Access to Media Type**

Form of disability	Read newspaper once a week	Watches Television once a week	Listen to radio once a week	No access	Total %
Visual	—	—	19	81	100
Physical	5	4	37	54	100
Hearing	15	31	—	54	100
Other	16	30	9	45	100
Total	9	16.5	16	58.5	100
ZDHS	24.5	36.3	48.0	43.7	100

**N=237,(WLWDs), 8907 (ZDHS)**

Further more, participants during an FGD also concurred with one woman who stated that;

*"Most forms of media do not speak our language. Its-either it does not address the visually handicapped or the hearing impaired"*

Apart from the aforementioned issue, key informants highlighted;

*"Radio or no radio, the truth is that these women spend most of their time begging and vending on the streets of Harare. Resultantly, they miss out in media programmes"*

## Contraceptive Use

Modern methods of contraception in Zimbabwe have been proven effective for birth control. However, results from the study reveal that contraceptive use is

very minimal among WLWD since 92%, 90%, 90% and 70% of the visually impaired, physically handicapped, hearing and other forms of disabilities respectively do not use contraceptives as shown on Table 1.2. This could be attributed to problems associated with stigma and general disadvantage in accessibility (distributive injustice). A further 17% of the WLWD reported to be using contraceptives compared to 61% of the women in the ZDHS. Eighty-three% of WLWD are currently not using any form of contraception compared to 39% of the women in the ZDHS.

**Table1.2: Percentage Distribution of Respondents on Current use of Contraception**

Form of disability	Yes	No	Total
Visual	7.9	92.1	100
Physical	18.1	89.9	100
Hearing	10.0	90.0	100
Other	30.0	70.0	100
Total	16.5	83.5	100
ZDHS	61.2	38.8	100

**N=237, WLWD ZDHS 8907**

Low contraceptive use has been attributed to the need for guidance and assistance for the women to carry out their activities every day. This was substantiated by the following remark in an FGD;

*"For me to earn a living, I have to keep on giving birth. I need a guide to the city centre every day and these children lead me. Three have already left to fend for themselves. These two (5 and 7 year olds) are not here for long. That's why I don't use any contraceptives. I am expecting as we speak."*

Attitudes of healthcare providers also contribute to low contraceptive use by WLWDs. A physically challenged woman in a FGD echoed the following sentiments that were endorsed by other participants;

*'I visited the family planning clinic and sat in the reception for so long. I decided to leave without being attended to'.*

## **Fertility**

Evidence reported suggests that the visually impaired women have the highest number of children ever born (CEB) since 70% have at least 3-4 children whilst 25% fall within the highest parity (5+ children) as indicated on Table 1.3. Comparatively, the rest of other forms of disabilities have at least a child ever

born with 67% of women with other forms of disabilities having at least one child. It was also notable that the physically handicapped constituted the highest percentage (37%) of those who never had a child.

**Table 1.3: Percentage Distribution of Respondents by CEB and Form of Disability**

Form of disability	None	1-2	3-4	5+	Total
Visual	1.0	3.7	70.0	24.9	100
Physical	36.7	50.0	13.3	—	100
Hearing	—	42.3	38.5	19.2	100
Other	14.7	66.7	18.7	—	100

**N=237, ZDHS 8907**

The key informants attributed this to the likelihood of birth complications by the physically impaired women as they stated;

*"It is not highly recommended for the physically impaired to keep on giving birth since they have other health problems"*

### **Maternal Health Care**

Results reported from the study revealed that the majority of WLWD do not utilize maternal health care services (MHCS) since only 26% and 21% (compared with ZDHS, 54% and 69%) ever attended antenatal and post natal care respectively (Table 1.4).

**Table 1.4: Percentage distribution of Respondents by Utilization of Maternal Health Care Services**

Findings from:	ANC	PNC
WLWD	25.5	21.1
ZDHS	53.7	68.5

**N=237 WLWDs and 8907(ZDHS)**

FGDs with the WLWD substantiated the above as they echoed;

*"As long as I feel strong enough, I cannot waste my money on someone who hasn't arrived. I have to put food on the table. Worse still, the clinics are not within my locality"*

## Condom Use

Results from the study indicate that the majority of the WLWD do not use condoms since 95%, 60%, 86% and 61% of the visually, physically, hearing impaired and other forms of disability respectively reported that they do not use condoms as shown on Table 1.5

**Table 1.5: Percentage Distribution of Condom use among WLWDs**

Form of Disability	Yes	No	Total
Visual	4.8	95.2	100
Physical	39.6	60.4	100
Hearing	13.9	86.1	100
Other	39.2	60.8	100
Total	24.4	75.6	100
ZDHS	74.7	25.3	100

**N=237, WLWDs, 8907(ZDHS)**

Overall, a quarter of WLWDs compared to three quarters of the 2005-6 ZDHS use condoms. Low condom use by WLWD has been attributed to inaccessibility of condoms. In an FGD most disabled women concurred with one woman who stated;

*'There are times when we desperately need condoms but they are hard to come by. We are also not free to ask for them'.*

Low contraceptive use among WLWD has been attributed (during FGDs) to myths that contraceptives cause either cervical cancer or sterility.

## STDs including HIV and AIDS

The lack of condom use among WLWD has come to fruition as results indicate that the majority of respondents reported that they had suffered from STDs across all forms of disabilities as shown on table 1.5. However, it is equally important to note that STDs are highly prevalent among the visually (79%) and hearing impaired (76%) women (Table 1.5).

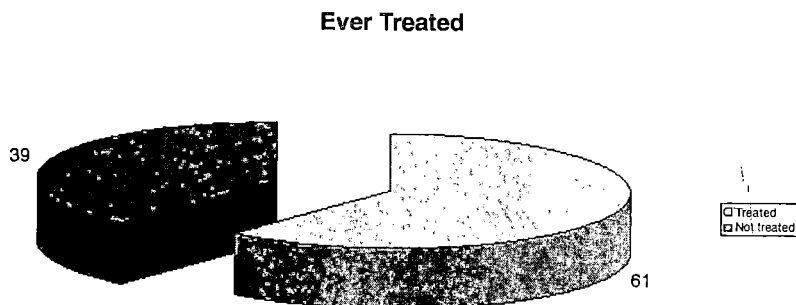
**Table 1.6: Percentage Distribution of STD Incidences among WLWD**

Form of disability	Yes	No	Total
Visual	79.4	20.6	100
Physical	57.1	42.9	100
Hearing	76.2	23.8	100
Other	60.0	40.0	100

**N=237**

From those that reported to have suffered from STDs, the majority (61%) received treatment whilst 39% did not receive any form of treatment and this might, in part, explain the effect of negative attitudes of health workers towards WLWD (Figure 1.2).

**Figure 1.2 Percentage Distribution of STD Treatment among WLWDs**



**N=237**

However, it was learnt during FGDs and key informant interview that a substantial number of those who received treatment used traditional methods. Fear of the service provider's attitude result in WLWD not seeking treatment and this was substantiated by a woman in a FGD who stated that:

*"It is not easy for a WLWD to go to a public place like a clinic to seek treatment for an STD for that matter. It is not easy to disclose such a disease at all because healthcare providers think that we are asexual. Most of us have no option besides visiting traditional healers in most cases at night"*

## Discussion

### Educational Attainment

The study revealed that education among WLWD is still very low. For instance, only 10% of the respondents attended secondary education and 15% attended tertiary education compared to 60% and 3% of the women studied in the Zimbabwe Demographic Health Survey (ZDHS) of 2006, yet education is key to making informed decisions for everyone's wellbeing. From the study, it was revealed

that WLWD generally miss out on attaining complete formal schooling. The participants attributed this situation to stigmatisation by the society. Thus, parental attitudes against the disabled girl have resulted in educating a disabled girl child as the least of their priorities. This is not an issue in a society where sons are highly preferred. To make matters worse, the Zimbabwean education system has not fully recognized the needs of WLWD. This concurs with Charowa's (2007) findings that there are fewer numbers of special schools which cater for children living with disabilities. This makes them spend most of their time trying to come to terms with peer attitudes towards them instead of focusing on learning. Such children may not perform well in school. As a result, they end up dropping out of school. It was also reported that parental attitudes, self attitudes and inaccessibility of schools had also resulted in some drop outs as well as some children never even attempting to attend formal schooling.

Such an educational background leaves WLWD isolated. They may find it very difficult to deal with the reproductive health challenges since they may be lacking essential knowledge. In Zimbabwe, the study has observed that society finds it normal to see WLWD suffering as they try to earn a living on the pavements of the city through begging and vending.

### **Exposure to the Mass Media**

Exposure to mass media provides the opportunity to experience new ideas and knowledge that is useful in various aspects of everyday life. In Zimbabwe just like any other country world wide, the media act as a tool for information dissemination about health and family planning. Studies carried out during the Zimbabwe Demographic Health Survey (2005/6) show that 25% of the women read newspapers once a week, 36% watch television while 48% listen to radio once a week while this study revealed that at least 59% of WLWD have no access to media at all.

Low media access is attributed to disability. For instance, a visually impaired woman cannot watch television or read newspapers while the deaf cannot listen to radio. The issue of affordability also impacts on media access by WLWD. The majority are not economically self sufficient and depend on vending and begging on the pavements of the city of Harare. Hence, putting food on the table becomes their first priority for any cent that comes their way.

Whilst one can argue that WLWD have access to media, it should be noted that in this particular study, some forms of media are not friendly to specific forms of disability. A case in point is where some information, education and communication (IEC) programmes on television do not carry subtitles for the deaf to get the message. Recently most of such programmes on family planning, STD, HIV and

AIDS and general health were on radio and television (TV). Thus, the deaf may not extract any information from both the radio and TV by merely seeing the pictogram. The blind also receive no news from the print media and TV, yet these people are part of the society where precaution has to be taken to protect oneself against infectious diseases and unwanted pregnancies. To make matters worse, WLWD in this study have very little or no formal education.

Life was going to be very easy for WLWD if the media gurus could consider their disability before broadcasting or publishing any piece of information. However, it looks like if this is ever going to be achieved the pace may remain slow. In this instance, WLWD remain in the periphery and hence the forgotten people.

### **Contraceptive Use**

Modern methods of contraception in Zimbabwe have been proven effective for birth control, STIs and HIV and AIDS. In fact, contraceptive use is increasing per annum from at least 48% in 1996 to 84% in 2006 (ZDHS, 2006). Knowledge about contraception seems to be universal since ZDHS (2006) stated that 98% of women in Zimbabwe are aware of at least a method of contraception. Comparatively, this study revealed that only 62% of WLWD are aware of at least a method of contraception whilst only about 15% currently use contraception.

Low contraceptive use among WLWD has been attributed to myths that contraceptives cause either cervical cancer or sterility. Such beliefs can be attributed to limited formal education and exposure to the media. Certain instances highlighted that WLWD especially the visually impaired, do not prefer contraception since they are always in need of company (normally provided by the 4-9 year olds). Above all, WLWD do not seek contraceptives out of fear of the attitudes of the healthcare providers who perceive them as asexual. In addition if a disabled woman is to have sex with an able bodied partner then the decision to use or not use any contraception lies with the partner as they lack adequate power to enforce decisions. As a result, non use of contraceptives seems to be the norm among WLWD and nothing is being done to improve their situation. It can also be argued that as long as contraceptive use remains low among WLWD, their fertility also remains high and their life style continues to be tough.

### **Children Ever Born.**

The visually impaired women have the highest parities among the WLWD. This is because as most participants reported, children act as aids when they carry out activities of daily living such as begging. The physically impaired have fewer children because of their kind of disability that expose them to pregnancy complications. Infact, some women studied highlighted that they were advised not to continue having children since delivery is in most cases through caesarian.

The study also revealed that some WLWD never had children. This is primarily due to failure to secure sexual partner.

As high fertility prevails among the visually handicapped women, this does not improve their situation as has been observed. Most of their children were reported not to be receiving formal education due to the costs incurred. Thus such women continue to have the burden of providing for their children from vending and begging.

### **Maternal Health Care Services**

The antenatal and post natal health care received by the mother is important for the well being of both the mother and the child. In Zimbabwe, 94% of the women receive antenatal care (ANC) while 54% receive postnatal care (PNC) for all pregnancies. Comparatively only 34% and 10% of the WLWD receive ANC and PNC respectively.

Acceptability, affordability and accessibility have been reported to be the underlying cause of limited or none utilization of maternal health care services. WLWD were reported to have been teased by the healthcare providers for having fallen pregnant. As a result, they avoid such services in most cases. To make matters worse, these women do not afford the costs for such services. Thus, priority is given to putting food on the table. As long as they can cope with activities of life, seeking health care may not be an issue. Such an attitude is attributed to lack of formal education vital for enlightening of women. Inaccessibility due to lack of mobility facilities (like transport) and/or finance to fund movements as well as distance factor are also some of the factors explaining poor utilization of MHCS.

### **Condom Use**

Condom use is one of the main strategies for combating the spread of STIs including HIV and AIDS. Although ZDHS (2006) did not focus on current condom use, the results from the WLWD studied indicated that only 24% of the respondents currently use condoms.

Information on constraints of effective use of condoms indicates that WLWD leave the entire decision on condom use to their male partners, who in most cases disapprove its use. Furthermore, being women and at the same time disabled implies that they are at lowest ebb of decision making. More so, key informants in this study argued that once WLWD manage to get a partner, they become so contented that they will do anything to please their partners.

Low condom use among WLWD has also been attributed to the attitude of the women towards condoms. It should be noted that WLWD shun condoms as they



believe that condoms are infected with HIV apart from being disgusting. In addition to that, most married women believe that condom use is associated with prostitution hence they don't want to use them. On the other hand, some claim that condoms are hard to access especially by the visually handicapped women who may not be free to go about asking for condoms. Worse still, instructions are not in Braille.

Apart from condoms not being user friendly to some WLWD, they feel intimidated to go to clinics for condoms as one reported to have been asked what she needed condoms for by the nurses at the clinic. Thus, society still perceives WLWD as asexual yet they are sexually active. This discourages them from seeking necessary health thereby exposing them to STIs including HIV and AIDS as well as unwanted pregnancies.

### **Sexually Transmitted Diseases including HIV and AIDS**

In developing countries, STIs and their complications are among the top five categories for which adults seek health care (Robertson and Ward, 2003: UNICEF, 2003: UNFPA, 2002: 2004: WHO, 2005) whilst HIV and AIDS is now a leading cause of death in sub-Saharan Africa and the fourth largest killer globally (UNAIDS, 2002). It is therefore vital for WLWD to have knowledge about the signs, prevention, treatment of STIs and HIV and AIDS as well as a positive attitude towards staying safe. It is notable from the study that awareness about STIs including HIV and AIDS is widespread among Zimbabwean women (98%) according to ZDHS (2005-6) and 97% among WLWD studied. Although WLWD studied were aware of STDs including HIV and AIDS, knowledge about the symptoms was very low as has been reported. This in the end affects STD treatment since they may take the symptoms for granted yet the STD is deadly and increases vulnerability to HIV infection.

WLWD studied are still laid back when it comes to their attitudes towards STDs. They still believe that affection shown to them by male partners is more important than the risk of getting infected with an STI. Reports from FGDs in this study have indicated that WLWD treasure sexual relationships and forget about STIs and HIV and AIDS. Some even reported that they never mind having an HIV infected partner since they believe that they will also be infected but seem to forget about re-infection. However, it is worthy noting that some WLWD acquire STIs through rape. Worse still, WLWD during FGDs reported that the blind and deaf are targeted by the perpetrators since they cannot give enough evidence to bring the offenders to book. A number of such cases have been given where the perpetrators have gone unpunished.

There is also a general belief by traditional healers that if one has sexual intercourse with a disabled woman, this helps to cure STDs including HIV and

AIDS. A case in point was given in Epworth, Harare where a blind girl was raped by a known HIV positive uncle with the help of the mother for the uncle to cure his HIV. The case is still in court as there is not enough evidence. When the law cannot protect the WLWD, they continue to be vulnerable and their problems seem to be forgotten always.

Health service providers have reported that WLWD seek treatment when it is too late. However, it should be noted that WLWD argued that this is so because they feel that health care providers do not treat them like other normal human beings since they always violate their privacy and confidentiality which is contrary to the requirements of the Patients' Charter which "... *guarantees patients the right to ...privacy and the right to confidentiality of treatment.*" (Centre for Reproductive Law and Policy, 2007). It should be argued that lack of privacy and confidentiality instill fear of stigmatization to WLWD by the family and community as in most cases, a third part is included. They therefore resort to traditional means as they fear the attitude of health service providers. This exposes them to HIV and AIDS and treatment under unhygienic conditions which may further worsen their problems.

## Recommendations

Disability issues, according to Cook et al (2003) ultimately lie in the hands of the government. It is vital to note that societal attitudes greatly contribute to the barriers fueling most of the RH problems faced by women living with disabilities. It is therefore important that such attitudes as well as the physical and knowledge based barriers be addressed such that disability does not appear as an issue. Once accomplished, this implies that such issues as accessibility, affordability, acceptability and availability would be easily handled by WLWD. The following are some of the proposed steps that may help in lessening the reproductive health problems faced with WLWD;

- There is need to sensitize communities about disability so that disability is seen as a community and not just a personal issue. These public attitudes towards the disabled can be changed by making people better informed, an awareness of WLWD as normal citizens with rights. This can be achieved by increasing knowledge about disability, reducing people's fears about disability.
- Of importance is to realize that many WLWD are destitute because they are no longer being supported by their families and are not empowered. They therefore earn a living out of begging and vending on the mean pavements of the cities. There is therefore great need to educate the disabled girl child so as to equip her with the knowledge that is enough to conquer their fears in society. Thus, the government with the support of the international community should protect and promote the rights of girls with disabilities to reproductive

health, education, information and care. This can however be achieved by providing more special schools.

- To address the issue of violence against WLWD, government is urged to introduce development policies in full support of the full participation and equality of WLWD in these areas. The policies should also highlight the needs for WLWD for example the Ministry of Women Affairs, Gender and Community Development have included disability issues in the Gender Policy. Government departments are requested to follow suit and the ministries are requested not to let documents gather dust in the offices.
- As has been mentioned before, disability issues ultimately lie in the hands of the government. There is need for deliberate inclusion of disability issues in such policies as the HIV and AIDS policy and the National Gender Policy which does not touch on women with disabilities in particular.

Train peer educators drawn from WLWD. These WLWD peer educators would be responsible for distributing condoms, contraceptive pills and disseminate IEC materials to WLWD.

- a) Training of RH and HIV service providers is vital if their attitudes have to be WLWD friendly. Thus, they have to be trained to view WLWD as people with sexual and reproductive needs that are unique to their state. Training health staff in sign language is vital to RH service utilization since confidentiality will be guaranteed.
  - b) For contraceptive use to improve there is need for RH programme to provide the service to WLWD and IEC on contraception to eliminate current beliefs about the dangers of contraception.
- WLWD should be educated about the prevention and management of STDs to reduce the high incidents reported by WLWD. Various forms of disability should also be considered so that the information reaches everyone. Thus, IEC should be with translated versions in local vernacular.

Since a high prevalence of sexual abuse was reported by key informants and some of the WLWD, the community should be made aware so as to protect the disabled women. Traditional healers should be arrested if they have been proven to be encouraging men to rape the disabled women in order to cure STDs including HIV and AIDS. Above all, the perpetrators of such crimes should receive tougher sentence. However, the law courts should rule in favour of the disabled once evidence of sexual abuse is given.

Since poverty is the overriding problem facilitating WLWD's RH problems, there is need to improve their status. Thus, WLWD should be moved out of the streets. This can only be done by:

- a) Establishing income generating projects that are within the capability of various forms of disability.
- b) Equipping the girl child with disabilities with skills to be self sufficient.
- c) Support the parents of children with disabilities to enroll them in schools since education is the only way skills can be acquired by anyone disabled or not.

Lastly, WLWD should be actively involved in the planning, implementation and evolution of activities that have an impact on their daily lives. This is especially important with respect to information, education and communication (IEC) activities and services concerning reproductive and sexual health.

### **Conclusion**

The study carried out among WLWD on the streets of Harare has revealed that WLWD can be referred to as the forgotten women. Their background of little or no formal education and less exposure to mass media has compromised their enlightenment and consequently their reproductive health. As a result, such reproductive health care services as contraceptives, condom use, as well as the maternal health care service utilization are not fully utilized by WLWD. These women's attitude (emanating from the fact that they are ill-informed) towards condom use exposes them to STIs including HIV and AIDS. To make matters worse, WLWD studied seem to be laid back when it comes to their attitude towards STIs. As long as all stake holders do not effectively reach out to them, WLWD remain the forgotten women.

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